Commonwealth of Massachusetts Title XXI

ANNUAL REPORT

Children's Health Insurance Program

Executive Summary

With the policy goal of increasing insurance coverage among the residents of the Commonwealth, the Massachusetts Division of Medical Assistance (the Division) utilized two mechanisms provided by the Federal Health Care Financing Administration (HCFA) to expand eligibility and coverage to children living in low-income families. As of December 31, 1998, the 1115 Research and Demonstration Waiver and the Children's Health Insurance Program (CHIP), have a total enrollment of 388,471 children. This represents an increase in enrollment by 21% for all MassHealth children since October 1, 1997. In the Commonwealth's Title XXI State Plan, the Division estimated covering at full enrollment, 37,100 CHIP eligible kids. The recent completion of the first fiscal quarter of FFY 99, MassHealth served 30,710 CHIP children as shown in the Division's Children's Health Program Quarterly Statistical Report for FFY 99.

In Massachusetts, where a large portion of the population is covered by employer-sponsored health insurance and where managed care penetration is high in the commercial market, the Division's policies are designed to support and strengthen the employer-sponsored health insurance market. All the large HMOs provide benefits that meet or exceed a basic benefit level and most meet the benchmark level for CHIP, including well child care, immunizations, and pharmacy. Rather than encouraging families to drop or forego employer-sponsored insurance because of cost, the Division's policies are designed to provide incentives to families to utilize the benefits that are available to them at their place of work.

One of the strengths of the Division's policies has been the use of a single, seamless process for application, eligibility determination, and enrollment in health plans, regardless of the applicant's eligibility category, coverage type or funding source for the health benefit. The standardization made the Division's policies easier to communicate and understand, and allowed the Division to embark upon a broad-based marketing campaign to encourage potentially eligible families and children to apply for MassHealth.

The Division's outreach endeavors have been successful in reaching and enrolling children from populations that previously had little knowledge of MassHealth and the eligibility criteria.

Another strength of MassHealth is the ability to respond rapidly to applicants. The new automated eligibility system has produced tremendous efficiencies in what used to be time-consuming processes, and reduced eligibility determination time (from receipt of a completed application to enrollment in MassHealth) from 24.0 days to 3.3 days. The managed care health delivery systems and providers with which the Division contracts have been able to accommodate the increase in enrollment without reducing access for MassHealth members. There are no indications that health plans have not maintained consistent quality. Many ongoing quality initiatives target children's health.

The largest implementation challenges are found in the start-up of Family Assistance. If families at 150-200% FPL have no access to health insurance through an employer, they can purchase coverage for their children directly from MassHealth. In cases where the employer offers insurance and the Division provides premium assistance toward the cost, the MassHealth policy removes financial barriers to insurance coverage by assisting with payment of premiums.

Rates of insurance among the children of the Commonwealth appear to be improving as a result of the expansion. All indications are that a greater percentage of children are presently covered as compared to those reported to be covered in the merged CPS data from 1994 through 1996. The recent study of health insurance coverage of residents performed under sponsorship of Massachusetts Division of Health Care Policy and Finance states that health insurance rates for children have increased in the two years since the prior survey in the Commonwealth. Recent data from a study by the Urban Institute show similar findings. Further corroboration of these encouraging results will probably be possible with future CPS reports.

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Introduction

To achieve its broad policy objective of increasing health insurance coverage for its residents, the Commonwealth of Massachusetts applied for and implemented dual options for accomplishing this goal with federal financial assistance. First, the Division expanded coverage to low-income populations through a HCFA 1115 Research and Demonstration Waiver (1115 Waiver). Second, it extended health coverage to children through the implementation of the Children's Health Insurance Program (CHIP). The Division designed this combination of expansions in eligibility to facilitate access to health insurance and to maximize insurance coverage to the populations least likely to have private coverage. A single, seamless process of application and eligibility determination applies to all non-institutionalized applicants under 65 years of age since July 1, 1997. The MassHealth programs are also designed to create incentives for employers to sponsor insurance whenever possible, and to create disincentives for low-income persons to drop

or forego employer-sponsored insurance when available. This report will highlight the operational aspects of the first year of implementation of CHIP, and comment on other MassHealth programs that affect the health insurance coverage of children. While it is still early to ascertain if these programs have had a net effect on overall insurance coverage rates for children, FY 1998 and first quarter FY 1999 enrollment statistics are promising. Indicators on changes in health insurance coverage and enrollment data are incorporated in Attachment I and Attachment II.

Brief History

At the beginning of FY 1998, the Commonwealth implemented certain provisions of its 1115 Waiver. The 1115 Waiver, approved by HCFA in April 1995 and the state legislature in July 1996 (Chapter 203 of the Acts of 1996), allowed the Division to streamline eligibility requirements and expand benefits to new populations. Under the 1115 Waiver, the Division expanded eligibility to children and parents whose incomes are at or below 133% of the Federal Poverty Level (FPL); pregnant women and children under 200% FPL; children with disabilities at or below 200% FPL; and, disabled children in families with incomes above 200% FPL upon payment of a premium (adjusted by family income).

Subsequently the state legislature (Chapter 170 of the Acts of 1997) authorized further expansions of eligibility to children whose family income is at or below 200% FPL. Federal law authorized CHIP in October 1997 and the Massachusetts legislature approved the CHIP expansion in November 1997. HCFA approved the Massachusetts CHIP State Plan in May 1998. With implementation beginning in August 1998, the children's expansion under Title XXI includes the following provisions:

> Expansion of Title XIX (MassHealth Standard) coverage for uninsured children through the age of 18 from 133% to 150% FPL.
>
> Assistance to families with family income between 150% and 200% FPL for uninsured children through the age of 18. Families with income above 150% FPL must contribute to the cost of coverage.
>
> Presumptive eligibility granted to children in families with self-declared income at or below 200% FPL for up to 60 days to cover health care expenditures while the family supplies additional information and verification as required.
>
> Expansion of coverage for pregnant women and their newborns from 185% to 200% FPL.

The 1115 Waiver allows the Division to implement new MassHealth eligibility rules designed to optimize the use of employer-sponsored health insurance, to encourage

employers to offer insurance, and to prevent "crowd out" of private health insurance among low income workers. For children who had access to employer-sponsored insurance, Massachusetts uses a combination of 1115 and Title XXI funds to provide coverage through the purchase of family health insurance policies when cost effective. Low income families who purchased employer-based insurance coverage for their children prior to health reform receive the same benefit (subsidy) as low income families getting employer-based health insurance for the first time. However, Title XXI program funds will only be used for eligible children who are uninsured. Coverage for children who do not meet CHIP criteria is provided under the 1115 Waiver or state-only funds.

Outreach Measures

According to a recent study by the Agency for Health Care Policy and Research, it is estimated that 4.7 million children in the United States are eligible for Medicaid, but are not enrolled in the program and have no other health insurance benefits. The report states that the number is much higher than previously estimated. After a decade of changes in the Medicaid program, which reduced the relationship between old welfare programs (AFDC) and Medicaid eligibility, and simultaneously expanded eligibility criteria for children, the authors reason that the absence of insurance may be due to lack of family awareness of their Medicaid eligibility, residence in areas where Medicaid coverage is less common, and a persistent stigma associated with Medicaid.

To counteract these national trends, the Division made every effort to implement broad-based outreach activities designed to draw attention of families, teachers, child care workers, health providers, youth and community organizations to enhanced opportunities in the Commonwealth for obtaining health insurance coverage for children. Beginning in July 1997, the Division embarked on a multi-modal outreach campaign to raise awareness about the availability of free/affordable health insurance for qualifying families and children. Repetitive messages were broadcast through direct mailings, press releases, newspaper inserts, health fairs and door-to-door canvassing of target neighborhoods. Attachment III contains a representative sample of the Division's marketing materials.

The Division conducted marketing efforts to optimize opportunities for free publicity whenever possible. These included:

high visibility press events and press releases

promotional materials to key contacts of eligible populations, such as doctors, teachers, child care workers, librarians, youth recreation workers, and summer camp counselors

distribution of fact sheets in key locations frequented by the eligible population such as human service organizations, community organizations, and food pantries

posters in public buildings and in public transit

special Hispanic outreach efforts in Latino communities such as radio spots on Spanish-language broadcast stations

1.5 million bilingual (English/Spanish) flyers produced for distribution to every child in public or parochial school or licensed day care in the Commonwealth. Additional flyers were also published in 10 other languages commonly spoken by MassHealth enrollees.

Establishing contact with every enrollee of the Children's Medical Security Program (eligibility up to 400% FPL without regard to immigration status) to inform them of expanded eligibility for MassHealth and to provide assistance in completing an application.

A single point of access, toll-free number for applying for health benefits.

The Division also coordinated its efforts with other state agencies, municipalities, community and advocacy organizations. Designated sites for providing services to children were enlisted in providing information about MassHealth to families with uninsured children. Among the agencies participating were Early Intervention Programs (DPH), school-based health centers (DPH), community primary care centers, Supplemental Nutrition Program for Women, Infants and Children (WIC) sites, HeadStart programs, Healthy Start, Case Management Program for Children with Special Health Care Needs (DPH), First Steps and Healthy Families Home Visiting Programs, and the Municipal Medicaid Program.

The Division also awarded mini-grants of $5,000 - $20,000 to community organizations to conduct outreach and provide assistance with the application. These organizations were based throughout the state geographically and had links to a variety of ethnic and foreign language groups, or special populations like the homeless. The Division arranged monthly regional meetings for recipients and other interested organizations to share best practices and discuss issues. Ten cities where large concentrations of income eligible populations were known to reside, were targeted for more intensive recruitment efforts.

By the end of the first year of the expansions, the Division identified several areas relative to outreach and marketing that are being addressed in the current year. The first observation is that it is extremely important to be sensitive to culture and language issues when working with immigrant populations. Second, MassHealth is still perceived among many working families to be available only to those on welfare. Third, MassHealth needs to provide ongoing member education to emphasize consumer responsibilities regarding complete reporting of income and/or changes in income, and access to employer-sponsored health insurance. The Division incorporated these measures into its eligibility re-determination process beginning July 1, 1998.

Streamlined Application and Eligibility Process

To become MassHealth members, the head of household typically fills out a Medical Benefit Request (MBR). Applicants must mail or fax their completed MBR to the Central Processing Unit in the Boston Office. The simplified four-page MBR asks for all the information required to establish eligibility based on gross family income. A minority of applicants also must fill out 1 to 4 supplemental pages if the applicants:

have other health insurance;

are disabled;

have immigrant status, or

have an absent parent.

Among the streamlined provisions of current eligibility criteria are use of gross rather than net income and elimination of the asset test (for non-institutionalized applicants under 65 years of age). These criteria are sufficient for the vast majority of children who are eligible for MassHealth Standard under both Title XIX and XXI. The simplified MBR is appended as Attachment IV.

A number of changes in the application itself, and the reduction in documentation required, have also helped improve productivity. The Division and the Department of Public Health (DPH) worked together to create a single application for medical benefits in Massachusetts. Previously DPH had conducted its own eligibility determination process for the Children's Medical Security Program (CMSP). Another major change under the Demonstration is the elimination of the Medicaid asset test for non-institutionalized applicants under 65 years of age. Prior to the Demonstration, verifying and checking an applicant's assets was the most time consuming task involved in processing applications. Since applicants at the lower income levels typically have no assets, checking assets was rarely productive for the Division, and may have delayed or discouraged applicants who would have been found eligible.

Applications are available to the public through community organizations, providers and the Division's outreach workers who cover 120 sites (hospitals, health centers, emergency rooms and other points of service) throughout the Commonwealth. The automated eligibility system has allowed eligibility workers of the Division to concentrate on customer service, enhancing the outreach activities and documentation efforts by answering questions and assisting applicants in completing applications. Division staff have received extensive customer training and are reported to be much more consumer friendly. Staff satisfaction has also improved as the role of eligibility workers has migrated, from predominantly record keeping and verification, to customer assistance.

Coverage Types for Children under the Title XXI Expansion

Title XXI and the 1115 Waiver expansions build upon existing coverage types and benefit packages at MassHealth. For the most part, children and their families are served by the same delivery systems of health plans and health providers, regardless of the category of assistance under which they became eligible for MassHealth. There are three coverage types for which Title XXI MassHealth children may be eligible: MassHealth Standard, MassHealth CommonHealth, and MassHealth Family Assistance. The following coverage types describe the benefits for children regardless of whether they are funded under Title XXI or the 1115 Waiver.

MassHealth Standard. Eligible children include all under age 19 with family income at or below 150% FPL, and pregnant women and infants less than one year of age with income at or below 200% FPL. Most MassHealth Standard members receive services under managed care arrangements (MCO, PCC and MH/SA). Standard services include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and unrestricted access to family planning services.

MassHealth CommonHealth. Disabled children (1-18 yrs.) living in households with incomes greater than 150% FPL, but less than or equal to 200% FPL, get all current MassHealth Standard services. MassHealth CommonHealth is also available to uninsured disabled children with family incomes above 200% FPL based on a sliding fee scale. All CommonHealth children receive their services on a fee-for-service basis from any approved MassHealth provider.

MassHealth Family Assistance. Family Assistance provides assistance to families with incomes between 150% and 200% FPL whose children are ineligible for MassHealth Standard or CommonHealth. They can obtain coverage for their children through two mechanisms.

Premium Assistance. For children under the age of 19 years who have access to employer-sponsored health insurance through a parent where the employer contributes at least 50% of the cost of the health insurance and meets the benchmark benefit level (equivalent to Harvard Pilgrim Health Plan, the HMO with the largest commercial enrollment in the Commonwealth), the Division provides assistance under CHIP toward the purchase of employer-sponsored health insurance. The cost to families will generally not exceed $10 per child or $30 per family per month. Families chose a health insurance plan from the offerings of the employer. The Division will pay for all co-payments and deductibles associated with well child visits, as well as pay co-payments and deductibles for all other health services for the eligible children that exceed certain limits. Total out-of-pocket expense to families for premiums, co-payments and deductibles will not exceed 5% of income.

Purchase of Medical Benefits. For children under age 19, who do not have access to employer-sponsored health insurance, the Division provides families the opportunity to purchase the MassHealth benefit package for their children under CHIP. The cost to families is no more than $10 per child or $30 per family per month. The benefit package is similar to MassHealth Standard but excludes long-term care, day habilitation, private duty nursing, and non-emergency transportation. The services will generally be provided under managed care arrangements (MCO, PCC, MH/SA).

Delivery Systems

MassHealth uses the same provider networks for its Title XIX and Title XXI programs. Once a child has been found eligible for MassHealth, health services will generally be provided through a managed care delivery system. During the first 60 days or less of presumptive eligibility, children may use any participating MassHealth provider on a fee-for-service basis. Once eligibility for managed care has been confirmed, however, the family, working through the contracted Enrollment Broker, selects or is assigned to a health plan and/or primary care provider within 30 days.

The family may choose one of several managed care organizations that contracts with the Division or select the Division's own Primary Care Clinician (PCC) Plan for its children. In Massachusetts, managed care penetration is among the highest in the nation for the population under 65 years of age. MassHealth contracts with several of the large, well-established HMOs in the state, giving MassHealth members a choice of HMOs that also serve the non-Medicaid population. In addition numerous MassHealth members have enrolled in managed care organizations that were originally an outgrowth of federally qualified neighborhood health centers and traditional safety net hospitals. The vast majority of families with children are enrolled in the Division's own PCC Plan. There are approximately 1300 PCC practices throughout the Commonwealth that have enrolled MassHealth members. There have been no capacity problems. Most practices were prepared for and able to accept the additional enrollment that resulted from the expansion of eligibility.

Regardless of the service delivery system the member chooses or is assigned, the focus of the enrollment/assignment process has been to provide each child and family with access to timely and appropriate primary care services and 24 hour back-up within reasonable travel time. In addition, efforts have been made to accommodate the transportation needs, cultural, ethnic and linguistic preferences of members. Some children are receiving primary care services through school-based health centers (SBHC). For these children the SBHC coordinates services with the child's health plan or primary care provider.

Family Assistance members with access to qualifying health insurance offered by an employer receive premium assistance towards that insurance. The benefits offered by

various employers will vary by an employer's choice of coverage. Family Assistance members covered through Title XXI will have insurance that meets or exceeds the benchmark benefit level. Members who have insurance are covered under the 1115 waiver, but maybe enrolled in employer sponsored health plans which also meet the benchmark level.

Quality Assurance and Specific Requirements for Children

The Division uses a combination of methods to assure the quality of its health care programs. Each managed care organization also participates in an annual Member Survey and in the collection of HEDIS data. In July 1998, the Division signed new five-year contracts with the MCOs and aligned their purchasing specifications to address the following areas:

Access

Quality

Mental health and substance abuse

Financial stability

The Division also negotiates annual Quality Improvement Goals for its contracted MCOs based on compliance with purchasing specifications and data collected during the prior year (HEDIS, Member Survey, and medical chart reviews). The Division develops two types of improvement goals: (1) standard that apply to all MCOs; and, (2) MCO-specific goals that relate to the need for a specific area of improvement for an individual MCO. The PCC Plan also sets goals for itself. These include goals related to provider communications, member education and maternal and child health activities. Among the quality improvement initiatives that are of particular importance for the health and well being of children are the following:

improving treatment and self-management for asthma;

improving the appropriate use of primary care and emergency medical services; and,

identifying and prioritizing activities that will improve the management of care for children and adolescents.

In addition the Division has distributed the EPSDT schedule to all PCC and MCO providers, fostered communication with SBHC and WIC, and worked to enhance care for children with special health care needs.

Finally, the Division has volunteered as one of the first states to work in collaboration with HCFA to increase the rate at which two year olds covered by Medicaid are fully

immunized (one of HCFA's GPRA goals). The Division is working to institute a variety of activities designed to assist PCCs and MCOs in ensuring that a greater percentage of their enrollees are fully immunized by age two. These activities include working with the state Department of Public Health's Immunization Program to improve state-required documentation forms, and educating providers about those forms; working to improve the communication of information between school nurses and primary care providers; and educating providers about maximizing opportunities for immunization, as well as about contraindications for vaccination. Because children enrolled in Family Assistance are enrolled for the most part in either the PCC Plan or a contracted MCO, Family Assistance members benefit from improvement activities instituted as a result of Massachusetts' participation as a GPRA volunteer state.

Based on HEDIS information, overall performance of managed care plans (including the PCC Plan) is good, often exceeding national and regional HEDIS commercial benchmarks. In several areas MassHealth managed care plan performance exceeds Healthy People 2000 goals. In HEDIS 1998, there are seven different HEDIS measures for children that relate specifically to immunization status. The HEDIS data for MassHealth MCOs, including the PCC Plan, indicate that the mean immunization status of children and adolescents in MassHealth is better than mean national HEDIS levels, but not as high as overall means for New England or Massachusetts. One MCO, Neighborhood Health Plan, exceeds the MassHealth median rate in a statistically significant manner for the majority of measures related to childhood immunizations.

Another aspect of Quality activities at the Division is the annual Member Survey, the most recent of which was conducted for the Division by the Center for Survey Research at the University of Massachusetts (Boston). Adults and children who had been enrolled for six months as of November 1997 were eligible for the survey. A total of 14,062 members were identified for the survey, and 5280 surveys were returned, yielding a response rate of 38%. All health plans (including the PCC Plan) had approximately 500 or more respondents. The Member Survey also produced some interesting findings regarding family perceptions of their children's care and the importance of communication in overall rating of plan quality. Among the findings are the following:

> 96% of respondents replied that their health care provider always or usually treated them in a friendly and respectful manner.
>
> For children whose health was rated as excellent or very good, 90% rated their overall care as excellent or very good.
>
> For children whose health was rated good, fair or poor, 69% rated the overall care provided by their health plan as excellent or very good.

Those MassHealth members who are enrolled in capitated managed care plans receive their mental health and substance abuse services from the HMO. Most MassHealth members, including those enrolled in the PCC Plan, however, receive behavioral health services from a contracted vendor, the Behavioral Health Partnership. The Division has

developed consistent purchasing specifications with respect to all MH/SA services across different health plans. One current goal is to improve crisis intervention for children and several aspects of coordination of care. The Division also conducts a number of regular meetings to assure contract compliance, to improve coordination between the Division, the contractor and the Department of Mental Health, and to elicit input from consumers, families and advocates.

During FY 1998 the Division also performed a trial run of its Encounter Data collection system. Beginning in FY 1999, 100% encounter data will be collected for the following clinical indicators pertaining to children's health:

1. prenatal care

    low birth weight/1000 births

    infant mortality rate

    post partum one month follow-up rate

    percent of women starting care during the first trimester

2. pediatric well care (immunizations)

3. pediatric asthma

    beds days/1000; and

    emergency room visit rate

Family Assistance

In addition to expanding the health insurance coverage of low-income children in the Commonwealth, the Division has the policy goal of encouraging expansion of employer-sponsored health insurance. The vast majority of poor and near-poor children who lack health insurance coverage qualify for health insurance, but cannot afford the premium

The Division has chosen to address this gap in insurance by covering eligible children without access to insurance through MassHealth at modest premiums and by subsidizing the purchase of employer-sponsored insurance where available. The route to covering eligible children with access to employer-sponsored insurance is through the purchase of family coverage with a combination of public, employer and employee funds. The latter is designed to:

provide incentives for families between 150-200% FPL to purchase employer-sponsored health insurance when offered;

stimulate a cost effective expansion of health insurance coverage for children through the purchase of family coverage that covers children as well as their parents; and,

help families to receive services from a single health plan.

In many ways, Family Assistance operates in the same way as all MassHealth programs. To establish eligibility, the family fills out an MBR. Upon filing the application with the required documentation of income, time-limited benefits are extended to the children, for up to 60 days, while the Division's contractor performs an insurance investigation on all applicants whose family income is 150-200% FPL. This may result in one of several findings:

Family actually has employer-sponsored health insurance. If the health insurance meets the benchmark level [*]* Title XXI** 1115 Waiveror the basic benefit level[*]2or the basic benefit level[**], the family is eligible for premium assistance. (If the employer-sponsored health insurance does not meet the BBL; then the family is not eligible for MassHealth.)

Family does not have, but has access to health insurance. The family enrolls in an employer-sponsored health insurance that meets the benchmark level or basic benefit level, the family is eligible for premium assistance. [*]2[*], the family is eligible for premium assistance. (If the employer-sponsored health insurance does not meet the BBL; then the family is not eligible for MassHealth.)

Family does not have, but has access to health insurance. The family enrolls in an employer-sponsored health insurance that meets the benchmark level or basic benefit level, the family is eligible for premium assistance. [**]

Family has no access to health insurance. Family can purchase MassHealth benefits directly for their children. [*]2[*]

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The process of screening applicants for Family Assistance eligibility was implemented in August 24, 1998. Several important observations with policy relevance have emerged from the process of discovering insurance and/or access to insurance and scrutinizing the benefits provided by different employer-sponsored policies. [2]

The process of screening applicants for Family Assistance eligibility was implemented in August 24, 1998. Several important observations with policy relevance have emerged from the process of discovering insurance and/or access to insurance and scrutinizing the benefits provided by different employer-sponsored policies. After only a few months, the Division can report several successful elements of this unique program.

Family Assistance works best when an entire family can get coverage. It is most successful for persons who have left Transitional Assistance to join the workforce, but who are employed in jobs that do not offer affordable health insurance. The Family Assistance (premium assistance) program makes family coverage affordable. This combination of incentives and premium assistance makes health insurance a good value for employer and employee alike.

The Division's intensive and broad-based marketing activities succeeded in enrolling many low-income children who were eligible for MassHealth, regardless of the program for which they qualified.

Most insurance policies offered by employers in Massachusetts meet the basic, and many meet the benchmark, level of benefits.

Family Assistance has also provided a few operational challenges:

Screening and investigating applicants and insurance coverage has been a time-consuming process because the employer of each applicant needs to be contacted, and each insurance policy has to be screened against the benchmark and basic standards. As staff increases their knowledge of employer-sponsored health insurance and develops a database on insurance coverage in the Commonwealth, the investigation time is expected to decline substantially. In the initial phase the effort has required hiring additional staff to build systems and perform investigations.

Because the ownership/management of a business is not always obvious to an employee, it can be difficult to locate the real employer and the person responsible for employee benefits. Many businesses have a name and location under which they do business (DBA) which is different from the name and location of the real business entity for tax identification purposes. In addition, job turnover is extremely common for this population.

Considerable effort has gone into devising an administrative system to handle co-payments and deductibles. MassHealth will pay providers directly for well childcare and immunizations, as well as for services that exceed 5% of family gross income. The Division's Care Kit contains instructions and forms for families to use to obtain payment. The Division will monitor the system to assure that families are receiving their benefits. The Care Kit is included in this report as Appendix V.

Assessment of Policy Impact

The Division's monthly enrollment report (unduplicated count of MassHealth membership) documents an increase in MassHealth membership from 317,344 children

on October 1, 1997 to 388,471 children on December 31, 1998, a 21% increase in the fifteen months since the implementation of CHIP. Using a slightly different count of eligible children, in the first quarter of the federal fiscal year 1999, 419,108 children were eligible for MassHealth benefits, of whom 30,710 were eligible under the CHIP program. Massachusetts is one of only a few states to have an increase of this magnitude in Medicaid enrollment of children during a time of low unemployment and declining welfare rolls. As of December 31, 1998 a total of 11,724 children in families with income levels between 150-200% FPL have been offered an opportunity to obtain insurance at modest cost since implementation Family Assistance in August 24, 1998. Of the referrals to Family Assistance, approximately one-half of children were found to be without access to insurance, but income eligible for direct purchase of MassHealth. They include 5737 children whose families purchase MassHealth benefits directly. Another 619 children are enrolled in employer-sponsored health insurance through the premium assistance program. In addition 5369 applicants have been granted time-limited benefits pending investigation of potential access to employer-sponsored insurance.

From a policy perspective, it was also intended that the net effect of expanding enrollment and providing premium assistance payments was to produce an overall reduction in the number of persons without health insurance. Policy in the Commonwealth was also formulated to address the problem of low-wage workers who decline employer-sponsored coverage even when it is offered because of the cost. Previously most Medicaid enrollees were unemployed. Recent developments, including de-linking of welfare eligibility from eligibility for MassHealth, high rates of employment, increasing rates of employer-sponsored health insurance, legislation forbidding discrimination based on pre-existing conditions, and extensive MassHealth outreach measures have produced conditions under which employer-sponsored health insurance and insurance take-up rates may increase.

Rates of health insurance among children of the Commonwealth appear to be improving as a result of the expansion. A study published recently by the Commonwealth's Division of Health Care Finance and Policy (DHCFP) finds that the number of uninsured residents of the state dropped by 179,000 (29%) from the previous study done in 1995. Contrary to national trends, the study also states that the number of uninsured Massachusetts residents fell from 11.4% of the population to 8.1% of the population during the three-year time period, 1995-98. The study reports that overall 5.3% of children (birth – 18 yrs.) in Massachusetts were uninsured. The same study indicated that among children <200% FPL, 13.2% were uninsured, but that among children >200% FPL, only 1.9% were uninsured. The study was based on telephone interviews conducted by the Center for Survey Research at the University of Massachusetts (Boston).

Recently the results of the Urban Institute's National Study of American Families (NSAF) corroborated the findings of the DHCFP survey. The NSAF study found lack of health insurance among 12.8% of children <200% FPL and 2.3% of children >200% FPL. The NSAF study is considered one of the few that provides reliable estimates in selected states (Massachusetts is one of the study states), as well as for the nation as a whole. Moreover, the survey pays particular attention to low-income families. Both of the

studies that took place in Massachusetts point to higher rates of health insurance than the latest available data from the Current Population Survey (CPS). Inconsistencies in the findings may be due to a number of factors such as differences in the time periods in which the data were collected, in sampling technique, and in methodology.

The Division will also measure the impact of its policy on insurance status of Massachusetts children at 0-200% FPL by tracking the changes in the CPS reports. The base line is the combined 1995-97 CPS data, which estimates the level and type of insurance of children in three age groups: birth –7 years of age, 7-12 years of age, and 13-17 years of age. The baseline statistics will be compared to CPS data and future studies, such the University of Massachusetts and NSAF studies as well as other corroborative evidence such as the reduction in the Uncompensated Care Pool.